STAR VISION CENTER **PATIENT HEALTH INFORMATION**

Name_____ Birth Date_____ Today's Date_____

In order to comply with Federal Regulations, please help us obtain a more thorough understanding of your health status and visual concerns, please complete both sides of this form, answering the questions as completely as you can.

MEDICAL HISTORY

- List Medications you are currently taking (prescription and over-the-counter). _____
  _____
- Do you have any allergies to medications? Y N If yes, please explain_____
- List major illnesses, injuries, and surgeries you have had. _____
  _____
- Name and office location of your medical doctors (s) _____
- When was your last eye examination? _____ Name of Doctor/Clinic _____
- Have you ever had your eyes dilated? Y N If yes, were there any problems? _____
- Do you wear glasses? Y N When do you wear your glasses? _____ How old are your glasses? _____
- Have you ever worn contact lenses? Y N Are you interested in wearing contact lenses? Y N
- Do you now wear contact lenses? Y N What type of Contact Lenses? Hard/RGP Soft Bifocal

FAMILY HISTORY

Please note any family members with the following conditions.

CONDITION	YES	NO	UNSURE	RELATIONSHIP
• Blindness				
• Glaucoma				
• Macular Degeneration				
• Arthritis				
• Cancer				
• Diabetes				
• Heart Disease				
• High Blood Pressure				
• Other				

SOCIAL HISTORY

- What is your occupation? _____ Do you use a computer at home/work? Y N
- List your hobbies/recreational activities. _____
- Does your occupation or hobbies/recreational activities require the use of safety eyewear? Y N
- Do you drive? Y N If yes, do you have visual difficulty when driving? Y N
- Do you use tobacco products? Y N If yes, what type/amount/how long? _____
- Do you drink alcohol? Y N If yes, how often? _____ Do you use illegal drugs? Y N
- Have you ever been exposed to HIV? Y N
- Have you ever been exposed to TB? Y N

- OVER -

REVIEW OF SYSTEMS Do you now have or have you ever had any of the following health conditions?

CONDITION	YES	NO	IF YES, PLEASE EXPLAIN
• Eye injury, pain, or surgery			
• Loss of Vision			
• Blurred Vision			
• Tired Eyes			
• Redness			
• Itching/Burning			
• Sandy or dry eyes			
• Excessive tears (watery eyes)			
• Vision Disturbance (spots, halos, light flashes)			
• Light sensitivity/glare			
• Double Vision			
• Glaucoma			
• Cataract			
• Macular Degeneration			
• Diabetic Retinopathy			
• Amblyopia			
• Eye turn (eso– or exotropia)			
• Keratoconus			
• Learning Disability			
• Constitutional (fever, weight loss)			
• Ears, Nose, Mouth, Throat (sinus, chronic cough, etc)			
• Respiratory (asthma, emphysema, etc)			
• Cardiovascular (high blood pressure, vascular disease)			
• Gastrointestinal (diarrhea, constipation, ulcers)			
• Genitourinary (genitals, kidney, bladder)			
• Muscles/Bones/Joints (arthritis, etc)			
• Endocrine (diabetes, thyroid, etc)			
• Psychiatric (anxiety, depression, etc)			
• Blood/Lymph (anemia, high cholesterol, etc)			
• Allergic/Immunologic (hay fever, lupus, etc)			
• Skin			
• Neurological (headaches, multiple sclerosis, etc)			

Who can we thank for referring you to our office? _____

Patient signature _____